Boston College Third World Law Journal

Volume 31 | Issue 2 Article 6

5-1-2011

The Right to Understand your Doctor: Protecting Language Access Rights in Healthcare

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THE RIGHT TO UNDERSTAND YOUR DOCTOR: PROTECTING LANGUAGE ACCESS RIGHTS IN HEALTHCARE

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Abstract: The current federal landscape governing language access in healthcare provides for inadequate enforcement and compliance. This Note examines existing language access laws to determine the legal rights of limited English proficiency (LEP) individuals to obtain healthcare services. This Note explores California's progressive work in ensuring language access rights for LEP individuals and recommends that states model their language access legislation after California's to guarantee language access in healthcare settings. Such legislation would remove barriers and promote greater access to healthcare for LEP patients.

Introduction

Thirteen-year-old Gricelda Zamora, the child of Spanish-speaking parents, often acted as family translator whenever the Zamora family interacted with the English-speaking outside world.[1] When, however, young Gricelda developed severe abdominal pain, requiring a trip to Mesa Lutheran Hospital in Arizona, the family found itself without an interpreter.[2] Gricelda herself was too ill to speak.[3] Although the hospital subscribed to a telephone translation service, it did not provide an interpreter for Gricelda's Spanish-speaking parents.[4] The emergency department physician diagnosed Gricelda with gastritis and discharged her.[5] The doctor informed Gricelda's parents in English that they should bring her back to the hospital if her condition deteriorated.[6]

* Managing Editor, Boston College Third World Law Journal (2010–2011).

[1] Alice Hm Chen et al., *The Legal Framework for Language Access in Healthcare Settings: Title VI and Beyond*, 22 J. Gen. Internal Med. 362, 362 (2007).

[2] *Id.*; Amanda Scioscia, *Language Isn't the Only Thing Getting Lost in the Translation as Hispanic Patients Struggle to Communicate with English-Speaking ER Doctors*, Phx. New Times (June 29, 2000), http://www.phoenixnewtimes.com/2000-06-29/news/critical-connection/.

[3] Scioscia, *supra* note 2.

[4] Chen et al., *supra* note 1, at 362; Scioscia, *supra* note 2.

[5] Scioscia, *supra* note 2.

[6] Chen et al., *supra* note 1, at 362.

Otherwise, they should schedule a doctor's appointment in three days.[7] Gricelda's parents, however, with their limited English, believed that the doctor had instructed them to wait three days before returning.[8] Two days later, Gricelda's pain worsened, and her parents brought her back to the emergency department a second time where she was diagnosed with a ruptured appendix.[9] The hospital arranged for Gricelda to be airlifted to a medical center in Phoenix.[10] Unfortunately, the diagnosis came too late, and Gricelda died shortly thereafter.[11]

Romualdo Rivera, who was also primarily Spanish-speaking, arrived at the emergency department at Temple University Hospital in Philadelphia, complaining of chest pains.[12] With the help of a hospital-provided interpreter, Romualdo was able to communicate effectively with the examining physician regarding his condition.[13] In addition, the physician was able to gather an adequate medical history because he was able to ask questions and receive answers with the interpreter's assistance.[14] Consequently, the doctor determined that the source of Mr. Rivera's pain was not his heart, but his stomach.[15] These divergent experiences demonstrate the critical importance of language access and the benefits to all parties.[16]

Unfortunately, miscommunications due to language barriers make stories like Gricelda's all too common.[17] Even worse, many more individuals are unable to obtain healthcare at all as a result of language barriers.[18] While access to healthcare is a significant challenge across the country, healthcare access problems are especially acute for minorities and immigrants.[19] Although rising healthcare costs and lack of

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[7] Scioscia, *supra* note 2.

[8] Chen et al., *supra* note 1, at 362.

[9] *Id.*

[10] *Id.*

[11] *Id.*

[12] *Hospital Interpreters Bridge Language Gaps, Lower Risks*, USA Today (Nov. 21, 2004), http://www.usatoday.com/news/health/2004-11-21-hospital-translators_x.htm.

[13] *Id.*

[14] *Id.*

[15] *Id.*

[16] *See* Chen et al., *supra* note 1, at 362; *Hospital Interpreters Bridge Language Gaps, Lower Risks*, *supra* note 12.

[17] *See* Chen et al., *supra* note 1, at 362; Glenn Flores, *Language Barriers to Health Care in the United States*, 355 New Eng. J. Med. 229, 229 (2006).

[18] *See, e.g.*, Eliza Barclay, *Speaking the Same Language: Medical Providers Struggle to Communicate with Immigrant Patients*, Wash. Post, Apr. 21, 2009, at F1.

[19] Leighton Ku & Demetrios G. Papademetriou, *Access to Health Care and Health Insurance: Immigrants and Immigration Reform*, *in* Securing the Future: U.S. Immigrant Integration Policy 83, 83 (Michael Fix ed., 2007). *See generally* Migration Pol'y Inst., http://www.mi-

health insurance are the primary obstacles to healthcare services, cultural and linguistic barriers exacerbate these problems for growing minority and immigrant communities.[20]

The United States has always been a nation of immigrants, but it has become even more diverse in recent years, with more than thirty-seven million Americans born in foreign countries.[21] According to the U.S. Census, almost fifty-five million people—nearly nineteen percent of the U.S. population—speak a language other than English at home.[22] Moreover, hundreds of languages are spoken across the country.[23]

As racial and ethnic diversity in the United States continues to increase, so does the need for effective language services to assist individuals with limited English proficiency (LEP).[24] LEP individuals include "persons born in other countries, some children of immigrants

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grationpolicy.org (last visited May 8, 2011) (highlighting challenges immigrants face regarding access to healthcare). Even insured Americans face difficulties accessing healthcare. Doug Trapp, *Health Care Access Problems Surge Among Insured Americans*, AM. MED. NEWS (July 21, 2008), http://www.ama-assn.org/amednews/2008/07/21/gvl10721.htm. As a result, healthcare access problems are more than "just about the uninsured and the insured." *Id.* According to a study performed by the Center for Studying Health System Change, one in five Americans did not receive or delayed the receipt of needed medical care in 2007. Peter J. Cunningham & Laurie E. Felland, *Falling Behind: Americans' Access to Medical Care Deteriorates, 2003–2007*, CENTER FOR STUDYING HEALTH SYS. CHANGE, 1 (June 2008), http://www.hschange.com/CONTENT/993/993.pdf. The National Immigration Law Center produced a report indicating that immigrants are less likely to be offered employer-sponsored health insurance and are more likely to be uninsured compared to citizens. *Health Care Expenditures for Immigrants Are* Lower *Than for Citizens*, NAT'L IMMIGR. L. CENTER, 1 (May 2009), http://www.nilc.org/immspbs/health/costs-less-than-citz-2009-05-26.pdf.

[20] Susan Okie, *Immigrants and Health Care—At the Intersection of Two Broken Systems*, 357 NEW ENG. J. MED. 525, 525 (2007); Cunningham & Felland, *supra* note 19, at 1, 2; Sarita A. Mohanty, *Unequal Access: Immigrants and U.S. Health Care*, IMMIGR. POL'Y FOCUS, 1, 6 (July 2006), http://www.immigrationpolicy.org/sites/default/files/docs/Unequal Access.pdf. The recent health reform, entitled the Patient Protection and Affordable Care Act (PPACA), attempts to achieve universal coverage through an individual mandate imposed on citizens and legal immigrants. *See* WASH. POST, LANDMARK: THE INSIDE STORY OF AMERICA'S NEW HEALTH CARE LAW AND WHAT IT MEANS FOR US ALL 1, 7, 85 (2010). Notably, PPACA does not address the coverage gap for illegal immigrants because it does not require them to comply with the individual mandate and furthermore does not allow them to purchase insurance from the state-based exchanges. *See id.* at 88.

[21] *See 2005–2009 American Community Survey 5-Year Estimates*, U.S. CENSUS BUREAU, http://factfinder2.census.gov (follow "2009 Population Estimates" hyperlink; then follow "Fact Sheet" hyperlink) (last visited May 8, 2011).

[22] *Id.*

[23] Jane Perkins, *Ensuring Linguistic Access in Health Care Settings: An Overview of Current Legal Rights and Responsibilities*, KAISER COMMISSION ON MEDICAID & THE UNINSURED, 3 (Aug. 2003), http://www.kff.org/uninsured/upload/Ensuring-Linguistic-Access-in-Health-Care-Settings-An-Overview-of-Current-Legal-Rights-and-Responsibilities-PDF.pdf.

[24] Mohanty, *supra* note 20, at 6.

born in the United States, and other non-English or limited English proficient persons born in the United States, including some Native Americans."[25] Thus, LEP individuals include both native-born and naturalized citizens, permanent residents, and illegal immigrants.[26]

Communication is essential to the effective delivery of healthcare.[27] Widespread language access will not only increase access to healthcare for LEP patients, but it will also improve the quality and cost-effectiveness of that care.[28] Surgeon and writer Dr. Pauline Chen notes, "Patients who speak English poorly or not at all face longer hospital stays, an increased risk of misdiagnoses and medical errors, and decreased access to acute and preventative care services, often regardless of socioeconomic or insurance status."[29]

The oft-cited excuse that language access services are cost-prohibitive fails to acknowledge the many economic benefits of providing such services.[30] Effective communication necessarily results in greater efficiency, both in terms of time and resources.[31] More accurate diagnoses would provide for decreased lengths of stay and facilitate patient turnover at hospitals.[32] Moreover, fluid conversation between patient and doctor would eliminate unnecessary diagnostic tests and thus reduce costs.[33] Language access services also lead to increased patient satisfaction and more efficient resource utilization.[34] Patients who need interpretation assistance are generally more satisfied with professionally trained medical interpreters than when family or friends help interpret.[35]

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[25] Enforcement of Title VI of the Civil Rights Act of 1964—National Origin Discrimination Against Persons with Limited English Proficiency; Policy Guidance, 65 Fed. Reg. 50,123, 50,124 (Aug. 16, 2000).

[26] *See id.*

[27] Lisa C. Diamond et al., *Getting By: Underuse of Interpreters by Resident Physicians*, 24 J. Gen. Internal Med. 256, 256 (2009).

[28] *Executive Summary: A Patient-Centered Guide to Implementing Language Access Services in Healthcare Organizations*, Am. Insts. for Res., 1, 2 (Sept. 2005), http://minorityhealth.hhs.gov/Assets/pdf/Checked/HC-LSIG-ExecutiveSummary.pdf [hereinafter *A Patient-Centered Guide*].

[29] Pauline W. Chen, *When the Patient Gets Lost in Translation*, N.Y. Times (Apr. 23, 2009), http://www.nytimes.com/2009/04/23/health/23chen.html.

[30] *See* Elizabeth A. Jacobs et al., *The Impact of an Enhanced Interpreter Service Intervention on Hospital Costs and Patient Satisfaction*, 22 J. Gen. Internal Med. 306, 306 (2007).

[31] *A Patient-Centered Guide*, *supra* note 28, at 2–3.

[32] *See id.* at 3.

[33] *Id.* at 2.

[34] *Id.* at 2–3.

[35] *Id.* at 2.

The need for language access services stems not only from social responsibility, but also from a legal responsibility.[36] Part I of this Note provides an overview of the legal framework supporting the mandate for language access in healthcare. Part II identifies problems and failures due to inadequate and inconsistent federal enforcement and implementation of appropriate and effective language access services. Part III details efforts of both states and private institutions to complement the federal landscape governing language access services in healthcare. Part IV examines California's language services program as a potential model to emulate. Finally, Part V suggests that other states adopt legislation, similar to California's, to protect the healthcare access rights of LEP individuals in the United States.

I. Legal Authority

A. *A Federal Mandate*

A mix of federal and state laws governs language access rights in the healthcare setting.[37] Although no congressional act expressly prohibits language discrimination, section 601 of Title VI of the Civil Rights Act of 1964 has been interpreted to protect against language discrimination.[38] The clause provides that "[n]o person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimina-

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[36] *See* Chen et al., *supra* note 1, at 362. An economic argument also exists to support increased immigrant access to healthcare. *See* Mohanty, *supra* note 20, at 1. LEP individuals are "less likely to use primary and preventive care services and more likely to use emergency rooms." Perkins, *supra* note 23, at 3. Additionally, delays in treatment could result in more serious conditions and subsequent treatment that is both less effective and more costly. Mohanty, *supra* note 20, at 6.

[37] Chen et al., *supra* note 1, at 362.

[38] *See* Title VI of the Civil Rights Act of 1964, Pub. L. No. 88-352, § 601, 78 Stat. 221, 252 (codified as amended at 42 U.S.C. § 2000d (2006)). The Supreme Court has noted the possibility that in some contexts "proficiency in a particular language . . . should be treated as a surrogate for race . . . ." Hernandez v. New York, 500 U.S. 352, 369, 371 (1991) (finding that a prosecutor did not discriminate on the basis of race when he struck two Spanish-speaking prospective jurors due to concerns that they would not defer to the court's translation of Spanish-language testimony). Similarly, the judiciary has determined that discrimination on the basis of language violates Title VI's prohibition against national origin discrimination. *See* Lau v. Nichols, 414 U.S. 563, 566–68 (1974); *infra* note 78. In particular, the United States Court of Appeals for the Ninth Circuit noted that "'an individual's primary language flows from his or her national origin.'" Barbara Plantiko, Comment, *Not-So-Equal Protection: Securing Individuals of Limited English Proficiency with Meaningful Access to Medical Services*, 32 Golden Gate U. L. Rev. 239, 245 n.38 (2002) (quoting Olagues v. Russoniello, 797 F.2d 1511, 1520 (9th Cir. 1986)).

tion under any program or activity receiving Federal financial assistance."[39] Title VI specifically applies to federally funded programs or activities, which in the healthcare context include hospitals, physicians, clinics, nursing homes, social service agencies, and other medical entities that receive federal funding.[40] As a result, much of the healthcare industry is subject to the language access mandate.[41]

The federal government and its agencies have also interpreted Title VI to mandate that recipients of federal aid provide language assistance.[42] Thus, the Civil Rights Act of 1964 is arguably the most important piece of federal legislation to provide a legal right to language access services.[43]

B. *Federal Enforcement of the Language Access Mandate*

On August 11, 2000, President Bill Clinton issued Executive Order 13,166, entitled "Improving Access to Services for Persons with Limited English Proficiency."[44] The Executive Order effectively required each federal agency to "develop and implement a system by which LEP persons can meaningfully access [the] services [it provides]."[45] Moreover, each agency was tasked with the goal of ensuring that recipients of federal aid also provide meaningful access for LEP individuals.[46] Overall, the result was a heightened awareness of the language access issue with respect to LEP individuals.[47]

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[39] 42 U.S.C. § 2000d.

[40] Chen et al., *supra* note 1, at 363; Allison Keers-Sanchez, Commentary, *Mandatory Provision of Foreign Language Interpreters in Health Care Services*, 24 J. Legal Med. 557, 563 (2003). Due to the limitations of Title VI, this Note assumes that hospitals and other medical entities are federally funded. *See* 42 U.S.C. § 2000d. To the extent that a healthcare facility does not receive any federal funds, it may nonetheless be subject to state regulations. *See infra* Part III.A. Private facilities are not implicated, but may be subject to common law tort liability. *See infra* Part III.C.

[41] *See* Chen et al., *supra* note 1, at 363; Keers-Sanchez, *supra* note 40, at 563.

[42] *See, e.g.*, 45 C.F.R. § 80.3(b)(2) (2010) (requiring all recipients of federal financial assistance from HHS to provide meaningful access to LEP persons); Enforcement of Title VI of the Civil Rights Act of 1964—National Origin Discrimination Against Persons with Limited English Proficiency; Policy Guidance, 65 Fed. Reg. 50,123, 50,124 (Aug. 16, 2000) ("[T]he significant discriminatory effects that the failure to provide language assistance has on the basis of national origin, places the treatment of LEP individuals comfortably within the ambit of Title VI and agencies' implementing regulations.").

[43] Chen et al., *supra* note 1, at 362.

[44] Exec. Order No. 13,166, 3 C.F.R. 289 (2000).

[45] *Id.*

[46] *Id.*

[47] *See* Chen et al., *supra* note 1, at 363.

In coordination with Executive Order 13,166, the Department of Justice (DOJ) issued a policy guidance document ("the LEP Guidance") that detailed the compliance standards that all federal aid recipients must meet in order to fulfill their Title VI obligations and to ensure that their programs and activities are accessible to LEP individuals.[48] Notably, the legal responsibility to provide language assistance has a wide reach, spanning across areas as diverse as education and police protection.[49] In the LEP Guidance, the DOJ set forth its understanding that Title VI requires federal aid recipients to "take reasonable steps to ensure 'meaningful' access to the information and services they provide."[50] "Reasonable steps" were to be defined in consideration of four factors: (1) the number or proportion of LEP individuals in comparison to the total number of individuals served; (2) the frequency of contact with the program; (3) the nature and importance of the program; and (4) the resources available to the recipient.[51]

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[48] Enforcement of Title VI of the Civil Rights Act of 1964—National Origin Discrimination Against Persons with Limited English Proficiency; Policy Guidance, 65 Fed. Reg. 50,123, 50,123–25 (Aug. 16, 2000) (clarifying existing Title VI responsibilities).

[49] *See, e.g.*, *Lau*, 414 U.S. at 566–67 (requiring language access in public schools); Memorandum of Agreement Between the United States of America and Town of Mattawa, Washington and Town of Mattawa Police Department 1 (Mar. 18, 2008), *available at* http://www.justice.gov/crt/lep/guidance/mattawa.pdf (settlement resulting from investigation of lack of language access in local police department).

[50] Enforcement of Title VI of the Civil Rights Act of 1964—National Origin Discrimination Against Persons with Limited English Proficiency; Policy Guidance, 65 Fed. Reg. at 50,124.

[51] *Id.* at 50,124–25. Analysis of each of the four factors would determine the extent to which language assistance should be provided such that,

> the greater the number or proportion of LEP persons, the more likely language services are needed[,] . . . the more frequent the contact with a particular language group, the more likely that interpreting or translating services in that language are needed[,] . . . the more important the recipient's service or program, the more likely language services are needed[,] . . . [and] smaller recipients with more limited budgets are not expected to provide the same level of language services as larger recipients with larger budgets.

Chen et al., *supra* note 1, at 363. The third factor in the DOJ's policy guidance document—the nature and importance of the program—affirms the need for language services in the healthcare context at a time when healthcare has become increasingly important and there is a burgeoning movement towards healthcare as a "right." *See* Enforcement of Title VI of the Civil Rights Act of 1964—National Origin Discrimination Against Persons with Limited English Proficiency; Policy Guidance, 65 Fed. Reg. at 50,125; *Transcript of Second McCain, Obama Debate*, CNN (Oct. 7, 2008), http://www.cnn.com/2008/POLITICS/10/07/presidential.debate.transcript/ (declaring that healthcare should be a right for every American). The DOJ clearly had healthcare in mind when it required further steps from programs with "life or death implications." *See* Enforcement of Title VI of the Civil Rights Act of 1964—National

Together, these factors balance the benefits of requiring language assistance against the risks of imposing cost-prohibitive burdens on smaller entities such as local governments and small businesses.[52] In addition to the four factors specified by the DOJ, the LEP Guidance advises recipients to consider the extent to which written or oral language services are necessary to ensure meaningful access for LEP individuals.[53]

Consistent with Executive Order 13,166, the U.S. Department of Health and Human Services (HHS) also issued its own policy guidance document two weeks later.[54] In doing so, HHS substantially adopted the DOJ's model, providing guidance to enable recipients to understand their own obligations as well as a framework for evaluating compliance.[55] Specifically, HHS requires recipients to provide oral and written language assistance at no additional cost to LEP individuals.[56]

With regard to oral interpretation, the HHS policy guidance document describes a range of oral language assistance options, both formal and informal.[57] Although HHS notes that friends and family members, including minor children, can serve as interpreters, it explicitly warns that a federal fund recipient "may expose itself to liability under Title VI if it requires, suggests, or encourages" the use of such persons.[58] Moreover, recipients must ensure that competent, but not necessarily formally certified, interpreters are made available.[59]

In addition, the HHS policy guidance document calls for the written translation of "vital" materials in languages other than English.[60] To

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Origin Discrimination Against Persons with Limited English Proficiency; Policy Guidance, 65 Fed. Reg. at 50,125.

[52] Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Original Discrimination Affecting Limited English Proficient Persons, 67 Fed. Reg. 41,455, 41,459 (June 18, 2002); Chen et al., *supra* note 1, at 363.

[53] Enforcement of Title VI of the Civil Rights Act of 1964—National Origin Discrimination Against Persons with Limited English Proficiency; Policy Guidance, 65 Fed. Reg. at 50,125.

[54] Title VI of the Civil Rights Act of 1964; Policy Guidance on the Prohibition Against National Origin Discrimination As It Affects Persons with Limited English Proficiency, 65 Fed. Reg. 52,762, 52,762 (Aug. 30, 2000).

[55] *See id.* at 52,765.

[56] *Id.* at 52,768.

[57] *Id.* at 52,766–67.

[58] *Id.* at 52,769.

[59] Title VI of the Civil Rights Act of 1964; Policy Guidance on the Prohibition Against National Origin Discrimination As It Affects Persons with Limited English Proficiency, 65 Fed. Reg. at 52,769.

[60] *Id.* at 52,767. A vital document "contains information that is critical for accessing the federal fund recipient's services and/or benefits, or is required by law." *Id.* at 52,773. The revised HHS policy guidance states that the classification of a document as "vital" is dependent on a number of factors such as "the importance of the program, information,

provide some certainty to recipients, the HHS policy guidance document contains a safe harbor provision for written translations.[61] According to the 2003 revised policy guidance, the safe harbor provision creates a presumption of compliance whenever an entity "provides written translations of vital documents for each eligible LEP language group that constitutes five percent or 1000, whichever is less, of the population of persons eligible to be served or likely to be affected or encountered."[62] However, if fewer than fifty LEP persons activate the five percent trigger, the entity can still receive safe harbor protection if it "provides written notice in the primary language of the LEP language group of the right to receive competent oral interpretation of those written materials, free of cost."[63] As a result, recipients who follow the suggestions of the provision can generally be assured of their compliance with the written translation requirements of Title VI.[64] Nevertheless, failure to adhere to the safe harbor provision does not signify noncompliance.[65]

To enforce Title VI of the Civil Rights Act, HHS maintains an administrative enforcement mechanism through its Office for Civil Rights (OCR).[66] OCR has authority to investigate complaints regarding language barriers, as well as to initiate its own investigations.[67] When a federal fund recipient violates its Title VI obligation, OCR will first attempt to negotiate a settlement before withholding federal funds for noncompliance.[68]

In addition to promulgating LEP guidance concerning language access, HHS, through its Office of Minority Health, has also developed language access standards specific to healthcare organizations.[69] The National Standards on Culturally and Linguistically Appropriate Ser-

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encounter, or service involved, and the consequence to the LEP person if the information in question is not provided accurately or in a timely manner." Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons, 68 Fed. Reg. 47,311, 47,322 (Aug. 8, 2003).

[61] Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons, 68 Fed. Reg. at 47,319.

[62] *Id.*

[63] *Id.*

[64] *Id.*

[65] *Id.*

[66] Perkins, *supra* note 23, at 5.

[67] *Id.*

[68] *Id.*

[69] *See* National Standards on Culturally and Linguistically Appropriate Services (CLAS) in Health Care, 65 Fed. Reg. 80,865, 80,872–79 (Dec. 22, 2000).

vices in Health Care were devised to "correct inequities that currently exist in the provision of health services and to make these services more responsive to the individual needs of all patients [and] consumers."[70] The standards were developed through an intense research, public comment, and review process.[71] Standards four through seven address language services and govern federal fund recipients because they are rooted in Title VI.[72]

C. *Limitation of the Right to Bring a Discrimination Claim Under Title VI*

In general, both the DOJ and HHS policy guidelines reflect an understanding that Title VI prohibits intentional discrimination as well as discrimination based on disparate impact.[73] Specifically, they prohibit federal aid recipients from "utiliz[ing] criteria or methods of administration which have the effect of subjecting individuals to discrimination because of their race, color, or national origin."[74]

The Supreme Court's decision in *Alexander v. Sandoval*, however, eliminated a private right of action under Title VI based on disparate

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[70] *Id.* at 80,873.

[71] *See id.* at 80,865. For all comments, see *id.* at 80,866–68.

[72] *See* Melinda Paras, *Straight Talk: Model Hospital Policies and Procedures on Hospital Access*, CAL. HEALTH CARE SAFETY NET INST., 43 (2005), http://www.calendow.org/uploadedFiles/straight_talk_model_hospital_policies.pdf. Standards four through seven of the CLAS language service standards state:

> 4) Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation
> 5) Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services
> 6) Health care organizations must assure the competence of language assistance provided to limited English patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer)
> 7) Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered group and/or groups represented in the service area

Paras, *supra*, at 60; *see* National Standards on Culturally and Linguistically Appropriate Services (CLAS) in Health Care, 65 Fed. Reg. at 80,875–76.

[73] *See* 45 C.F.R. § 80.3(b)(2) (2010). While intentional discrimination requires intent, actions with a disparate impact may be unintentional but nonetheless adversely affect or limit a particular group. *See* Alexander v. Sandoval, 532 U.S. 275, 285–86 (2001) (distinguishing the discriminatory effect justifying relief in *Lau* from the discriminatory intent now required for a Title VI claim).

[74] 45 C.F.R. § 80.3(b)(2).

impact.[75] Relying on the absence of congressional intent, the Court held, in a five-to-four decision, that an individual could only bring a Title VI claim in cases of intentional discrimination.[76] Nonetheless, the Court hinted that an individual may be able to bring a course of action based on a disparate impact theory in state court.[77]

Thus, the Court rejected its earlier interpretation that Title VI protected against more than just intentional discrimination.[78] The dissent, however, criticized the majority for improperly rejecting established precedent and interpreting the statute in a way that "[did] violence to both the text and the structure of Title VI."[79] The dissent further argued that, as recognized in prior cases, Congress did intend to include a private right of action for disparate impact cases.[80]

Nevertheless, as a result of the majority's ruling in *Sandoval*, a plaintiff must show that the federal fund recipient acted with discriminatory intent in failing to provide language services.[81] This is significantly more difficult than proving disparate impact discrimination because the individual must show that the recipient both intended to discriminate and knew that it was discriminating against the individual.[82] Because

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[75] *Sandoval*, 532 U.S. at 285. In *Sandoval*, the plaintiff brought a Title VI claim against the Alabama Department of Public Safety for offering driver's license examinations exclusively in English. *Id.* at 279. She claimed that the department's failure to provide the test in Spanish had a disparate impact on non-English speakers. *Id.*

[76] *Id.* at 277, 285, 289.

[77] *See id.* at 287 ("'Raising up causes of action where a statute has not created them may be a proper function for common-law courts, but not for federal tribunals.'" (quoting Lampf v. Gilbertson, 501 U.S. 350, 365 (1991))).

[78] *Id.* at 285. In *Lau v. Nichols*, Chinese students who could not speak English brought suit against the San Francisco school system for neglecting to provide supplemental English language instruction. 414 U.S. at 564. The Court determined that the students had a right under Title VI to receive bilingual education such that they would be afforded a meaningful opportunity to participate in the educational system. *Id.* at 566, 568. Thus, under *Lau*, federal fund recipients are required to ensure that language barriers do not exclude non-English speaking individuals from meaningful participation in their benefits and services. *Id.* at 566–68. Notably, the Court did not question Lau's interpretation of Title VI's national origin clause to prohibit discrimination on the basis of language. Perkins, *supra* note 23, at 7.

[79] *Sandoval*, 532 U.S. at 294, 304 (Stevens, J., dissenting).

[80] *Id.* at 297 (discussing Cannon v. Univ. of Chi., 441 U.S. 677 (1979)).

[81] *See id.* at 285 (majority opinion).

[82] Perkins, *supra* note 23, at 6. As one practitioner noted, "Such a showing [of intentional discrimination] is an almost impossible burden of proof that makes the law useless for dealing with the current manifestations of discrimination." Gordon Bonnyman, *Dynamic Conservatism and the Demise of Title VI*, 48 ST. LOUIS U. L.J. 61, 71 (2003). A disparate impact claim requires a plaintiff to show that a facially neutral practice, adopted without discriminatory intent, has a disproportionate impact on a protected class. Mona T. Peter-

Sandoval did not explicitly void Title VI disparate impact regulations, however, federal agencies continue to enforce LEP regulations through their own civil rights offices in cases of disparate impact.[83]

D. *Other Federal Laws Governing Language Access*

Beyond Title VI, an array of federal requirements ensures the provision of language access services.[84] Notably, the Hospital Survey and Construction Act requires hospitals to improve language access in healthcare.[85] Moreover, government-funded health insurance programs such as Medicaid, Medicare, and the Children's Health Insurance Program have functioned as vehicles for the expansion of language access services within healthcare delivery.[86] For example, Medicaid promotes the availability of language assistance services by offering federal matching funds to states.[87]

The Hospital Survey and Construction Act, popularly known as the Hill-Burton Act, was enacted in 1946 to provide federal grants and loans to facilitate the physical "construction and modernization" of the nation's public and nonprofit hospitals.[88] Widespread access to healthcare was a critical goal of the legislation.[89] Facilities that receive Hill-Burton funding are subject to a "community service" obligation, which requires the recipient to make services "available to all persons residing . . . in the facility's service area without discrimination on the ground of race, color, national origin, creed, or any other ground unrelated to an individual's need for the service or the availability of the needed service in the facility."[90] OCR, in enforcing the Hill-Burton Act, has interpreted

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son, Note, *The Unauthorized Protection of Language Under Title VI*, 85 Minn. L. Rev. 1437, 1452 (2001).

[83] Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons, 67 Fed. Reg. 41,455, 41,455, 41,458 (June 8, 2002) ("*Sandoval* did not invalidate any Title VI regulations that proscribe conduct that has a disparate impact on covered groups . . . .").

[84] *See* Paras, *supra* note 72, at 36–58 (summarizing key language access laws, policies, and requirements in Appendix C).

[85] *See id.* at 41.

[86] *See id.* at 41–42.

[87] Chen et al., *supra* note 1, at 365. Still, each state retains the discretion to decide "whether and how its Medicaid program will provide reimbursement for interpreting, and providers cannot receive payments for these services unless the state chooses to provide them." *Id.*

[88] *See* Hospital Survey and Construction (Hill-Burton) Act of 1946, Pub. L. No. 79-725, 60 Stat. 1040 (codified as amended at 42 U.S.C. § 291 (2006)).

[89] *See* Michael A. Dowell, *Hill-Burton: The Unfulfilled Promise*, 12 J. Health Pol., Pol'y & L. 153, 159 (1987).

[90] 42 C.F.R. § 124.603(a)(1) (2010).

the non-discrimination provision to require hospitals to provide language assistance services to LEP patients.[91] Past OCR administrative remedies have required hospitals to "[e]stablish procedures for communicating with LEP patients at all hours of a facility's operation" and to "[n]otify patients that interpretive services are available," among other things.[92]

II. Limitations of Existing Federal Enforcement Mechanisms

Federal enforcement mechanisms for securing non-discriminatory language access have long been criticized for being inefficient and inadequate.[93] First, the federal government has little power to compel private actors, such as insurers and physicians, to provide language access services to LEP individuals because such actors do not receive federal funds.[94] Although many private physicians do receive Medicare payments, they are excluded from Title VI's reach because Medicare payments are not considered federal financial assistance.[95]

Additionally, as noted earlier, an individual only has a cause of action for intentional discrimination because *Sandoval* limits an individual's judicial options.[96] Beyond that, an LEP patient's only recourse against a federal fund recipient who fails to offer needed language services is to file an administrative complaint with the appropriate OCR, which in the healthcare context is the OCR of the Department of Health and Human Services.[97] Fortunately, no standing requirements are necessary in order for an individual to file a complaint.[98] So long as an individual files a timely civil rights complaint, then the complaint will

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[91] *See* Jane Perkins, *Overcoming Language Barriers to Health Care*, Popular Gov't, Fall 1999, at 38, 42.

[92] *See* Paras, *supra* note 72, at 41.

[93] *See, e.g.*, Sidney D. Watson, *Health Care in the Inner City: Asking the Right Question*, 71 N.C. L. Rev. 1647, 1669 (1993).

[94] *See* 42 U.S.C. § 2000d (2006).

[95] Siddharth Khanijou, Student Article, *Rebalancing Healthcare Inequities: Language Service Reimbursement May Ensure Meaningful Access to Care for LEP Patients*, 9 DePaul J. Health Care L. 855, 866 (2005).

[96] Alexander v. Sandoval, 532 U.S. 275, 285, 293 (2001).

[97] Audrey Daly, Comment, *How to Speak American: In Search of the Real Meaning of "Meaningful Access" to Government Services for Language Minorities*, 110 Penn St. L. Rev. 1005, 1023 (2006); Keers-Sanchez, *supra* note 40, at 568.

[98] *How to File a Complaint*, U.S. Department of Health & Hum. Services, http://www.hhs.gov/ocr/civilrights/complaints/index.html (last visited May 8, 2011) ("Anyone can file written complaints with OCR.").

be reviewed and investigated.[99] An investigation may include interviews, document review, and site visits.[100] Then, OCR will issue a closure letter informing the relevant parties whether the alleged discriminatory act constitutes a violation of federal law.[101] If OCR finds a violation, the offending entity must take affirmative steps to redress its transgression.[102] For instance, a federal fund recipient may redesign its language assistance policies and procedures or provide notice to LEP clients regarding the availability of language access services.[103] If the offending entity fails to take action to correct its violation, OCR may refer the matter to the DOJ for enforcement.[104] Termination of federal funds is usually the punishment of last resort.[105]

Although laudable, OCR's attempts to resolve language access-related problems have been inadequate.[106] Its complaint process neither remedies specific past offenses of the federal fund recipient nor provides a remedy to the wronged individual.[107] An OCR investigation will only result in reform to the federal fund recipient's future practices, providing no actual relief to the LEP individual who was the victim of language discrimination.[108] Additionally, the development and implementation of language assistance policies and procedures may take a

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[99] Daly, *supra* note 97, at 1023; *How to File a Complaint*, *supra* note 98. A complaint is timely if it is filed within 180 days of the date of the alleged discriminatory act. *How to File a Complaint*, *supra* note 98. Often, legal aid organizations representing an LEP individual will file a complaint. Daly, *supra* note 97, at 1024; *see also* Plantiko, *supra* note 38, at 249 (describing when an Ohio legal services organization brought suit on behalf of LEP patients).

[100] *How Does OCR Investigate a Civil Rights Complaint?*, U.S. Department of Health & Hum. Services, http://www.hhs.gov/ocr/civilrights/faq/Complaint Procedures/303.html (last visited May 8, 2011).

[101] *Id.*

[102] *Id.*

[103] *See id.*; *see also Enforcement Success Stories Involving Persons with Limited English Proficiency*, U.S. Department of Health & Hum. Services, http://www.hhs.gov/ocr/civilrights/activities/examples/LEP/index.html (last visited May 8, 2011) (providing examples of corrective actions).

[104] *See How Does OCR Investigate a Civil Rights Complaint?*, *supra* note 100; Perkins, *supra* note 23, at 5.

[105] *See* Perkins, *supra* note 23, at 5.

[106] *See* Daly, *supra* note 97, at 1024; Khanijou, *supra* note 95, at 866; Peterson, *supra* note 82, at 1451.

[107] *See* Title VI of the Civil Rights Act of 1964; Policy Guidance on the Prohibition Against National Origin Discrimination As It Affects Persons with Limited English Proficiency, 65 Fed. Reg. 52,762, 52,771 (Aug. 30, 2000).

[108] *See id.* Such remedies include the requirement that federal fund recipients develop an LEP service plan or post translated signs notifying LEP patients about the availability of free interpreter services. Perkins, *supra* note 23, at 13.

long time, and it may take additional time before benefits are realized.[109]

Additionally, OCR arguably lacks the resources to fulfill its educational and monitoring functions.[110] As a result, much of the agency's energies are directed towards reactionary measures rather than preventative actions.[111] Consequently, at the federal level, OCR is an incomplete enforcement mechanism.[112] Thus, despite the federal mandate for language access, there is no proper incentive to provide such services because the law and regulations are not closely monitored and enforced by OCR.[113] The federal government needs to do significantly more to enforce the language access rights of LEP individuals to ensure that they are given access to needed healthcare.[114]

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[109] Daly, *supra* note 97, at 1024.

[110] *See* Sidney D. Watson, *Reforming Civil Rights with Systems Reform: Health Care Disparities, Translation Services, & Safe Harbors*, 9 WASH. & LEE RACE & ETHNIC ANC. L.J. 13, 25 (2003) ("Chronically underfunded and understaffed, DHHS/OCR's Title VI enforcement record is dismal."); *see also Detailed Information on the Health and Human Services—Office for Civil Rights Assessment: Program Performance Measures*, EXPECTMORE.GOV, http://www.whitehouse.gov/omb/expectmore/detail/10003523.2005.html#performanceMeasures (last visited May 8, 2011) [hereinafter *Performance Measures*]. As an office, OCR is responsible for the enforcement of several nondiscrimination statutes in addition to the Health Insurance Portability and Accountability Act, which protects individual privacy of health information. *See Detailed Information on the Health and Human Services—Office for Civil Rights Assessment: Questions/Answers (Detailed Assessment)*, EXPECTMORE.GOV, http://www.whitehouse.gov/omb expectmore/detail/10003523.2005.html#questions (last visited May 8, 2011). The agency has previously acknowledged that it receives more cases than it is able to resolve in a year. *See Performance Measures*, *supra*. As a result, the resolution of civil rights cases may be subject to a lengthy delay. *See id.* Civil rights complaints requiring formal OCR investigation take significantly longer to resolve than complaints that do not require formal investigation. *See id.* In 2009, only thirty-one percent of civil rights complaints requiring formal investigation were resolved within 365 days. Office for Civil Rights, *FY 2011 Online Performance Appendix*, U.S. DEPARTMENT OF HEALTH & HUM. SERVICES, 4 (2010), http://www.hhs.gov/ocr/office/about/opa2011.pdf.

[111] *See* Daly, *supra* note 97, at 1024; Peterson, *supra* note 82, at 1451.

[112] *See* Daly, *supra* note 97, at 1024; Khanijou, *supra* note 95, at 866; Peterson, *supra* note 82, at 1451.

[113] *See* Title VI of the Civil Rights Act of 1964; Policy Guidance on the Prohibition Against National Origin Discrimination As It Affects Persons with Limited English Proficiency, 65 Fed. Reg. 52,762, 52,771 (Aug. 30, 2000) (noting that compliance review is focused primarily on larger recipients).

[114] *See* Chen et al., *supra* note 1, at 365.

III. Filling in the Gaps

A. *State Laws*

In addition to federal laws, state laws provide additional protection for LEP individuals in the healthcare setting.[115] All fifty states have adopted measures addressing language access in healthcare settings.[116] Moreover, most states have established agencies or offices to tackle a broad range of minority health issues.[117] The variety of state laws addressing language access and discrimination "is the result of a legislative process driven variably by changing demographics, advocacy groups, adverse outcomes due to language barriers, the political climate of each state, and underlying political agenda."[118] Not surprisingly, states with significant minority populations have led the drive for minority healthcare reform.[119]

Some states, such as California, have required that healthcare providers offer specific language assistance while other states, such as Illinois, have simply encouraged healthcare providers to improve language access.[120] Others link language access to specific health services.[121] A number of other states link language access requirements

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[115] *Id.* at 363. Some local governments have also taken the initiative to ensure language access services for LEP individuals. *See, e.g.*, Language Access Act of 2004, D.C. Code Ann. §§ 2-1931 to -1936 (LexisNexis 2001). Notably, the D.C. Language Access Act requires government agencies, departments, programs, and services to provide oral language services to LEP individuals and written translations to any non-English speaking community which makes up the lesser of three percent or 500 individuals of the population served. *Id.* §§ 2-1932 to -1933.

[116] Jane Perkins & Mara Youdelman, *Summary of State Law Requirements: Addressing Language Needs in Health Care*, Nat'l Health L. Program, 4 (Jan. 2008), http://www.healthlaw.org/images/stories/issues/nhelp.lep.state.law.chart.final.0319.pdf.

[117] Kala Ladenheim & Rachel Groman, *State Legislative Activities Related to Elimination of Health Disparities*, 31 J. Health Pol., Pol'y & L. 153, 157 (2006).

[118] Chen et al., *supra* note 1, at 364.

[119] *See* Ladenheim & Groman, *supra* note 117, at 153. In particular, the state legislatures of California, Florida, and Louisiana have been extremely proactive in passing minority health legislation. *Id.*

[120] Perkins, *supra* note 23, at 16. *Compare* Cal. Health & Safety Code § 1259 (West 2008) (requiring language assistance), *with* Language Assistance Services Act, 210 Ill. Comp. Stat. Ann. 87/1–19 (2008) (encouraging language assistance). Massachusetts, New York, and Washington are also among the few states that have passed language access laws with specific requirements for healthcare providers. *A Patient-Centered Guide*, *supra* note 28, at 4.

[121] Chen et al., *supra* note 1, at 364. For example, several states, such as Arkansas, Kansas, Louisiana, Michigan, Minnesota, Nevada, North Dakota, Oklahoma, Texas, and Virginia have enacted "Women's Right to Know" Acts, which "typically require information about adoption, fetal pain associated with abortion, and possible detrimental effects of abortion to be translated into non-English languages, often at a much lower threshold

to licensing conditions for specific healthcare facilities.[122] Some states, such as California, New Jersey, and Washington, also require healthcare professionals to undergo cultural competency instruction as part of their continuing education.[123] Furthermore, a small number of states are moving to require the certification of healthcare interpreters in an effort to ensure competent interpretation.[124] Overall, such laws have been piecemeal and inconsistent from state to state.[125] Nonetheless, such laws have supplemented federal legislation, broadening the scope of language access rights.[126]

B. *Accreditation Programs*

Supplementing federal and state efforts, private accreditation agencies have also pushed to expand language access services through their influence over healthcare providers.[127] These agencies not only accredit healthcare organizations after rigorous review, but also establish standards for quality of care in healthcare delivery.[128] Healthcare organizations and insurance plans willingly subject themselves to agency scrutiny and review because accreditation can boost reputation and provide a competitive market advantage.[129] Additionally, in negligence cases, courts have considered these professional accreditation standards as evidence in defining reasonable care.[130]

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than required for other interpretation or translation services." *Id.* New Jersey requires information on breast cancer to be available in Spanish and English. *Id.*

[122] *Id.*; Lisa C. Ikemoto, *Racial Disparities in Health Care and Cultural Competency*, 48 ST. LOUIS U. L.J. 75, 113 (2003). For example, in Colorado, New Jersey, and Rhode Island, medical facilities will not be licensed if they do not provide adequate interpretation services. *See* Chen et al., *supra* note 1, at 364 & 367 n.17.

[123] Perkins & Youdelman, *supra* note 116, at 5. For instance, New Jersey requires completion of cultural competency instruction as a condition for both the conferment of a medical school diploma and licensure. *See* N.J. STAT. ANN. § 45:9-7.3 (West 2004).

[124] *See* Chen et al., *supra* note 1, at 364–65. For example, the Indiana legislature established an independent commission charged with developing training and practice standards for health interpreters and translators. IND. CODE § 16-46-11-1 (2007). Arguably such legislation is an attempt to remedy situations where an inappropriate person, such as a janitor or young child, is pulled in to interpret for the LEP patient. *See* Esther B. Fein, *Language Barriers Are Hindering Health Care*, N.Y. TIMES, Nov. 23, 1997, at 1.

[125] Chen et al., *supra* note 1, at 363.

[126] *Id.*

[127] *See* Paras, *supra* note 72, at 49.

[128] *Id.*

[129] *See id.* For example, accreditation by the National Committee for Quality Assurance is a "widely recognized symbol of quality." *About NCQA*, NAT'L COMMITTEE FOR QUALITY ASSURANCE, http://www.ncqa.org/tabid/675/Default.aspx (last visited May 8, 2011).

[130] *See* Jessica J. Flinn, Comment, *Personalizing Informed Consent: The Challenge of Health Literacy*, 2 ST. LOUIS U. J. HEALTH L. & POL'Y 379, 380 (2009).

The Joint Commission, formerly known as the Joint Commission on Accreditation of Healthcare Organizations, is the "largest standards-setting and accrediting body in health care" for healthcare providers.[131] It develops benchmarks that indicate the level at which safe and effective healthcare should be delivered.[132] In an acknowledgement of the increasing diversity of patients, the Joint Commission initiated a study entitled "Hospitals, Language, and Culture," which endeavors to understand the current state of healthcare delivery and develop recommendations for hospitals to cater effectively to culturally and linguistically diverse populations.[133] In particular, the Joint Commission developed recommended standards to "advance the issues of effective communication, cultural competence, and patient- and family-centered care" in hospitals.[134] Nevertheless, some existing standards already implicate language assistance—for example, one standard requires organizations to ensure effective communication between the patient and organization.[135]

The National Committee for Quality Assurance (NCQA) is the primary accrediting program for health plans.[136] Like the Joint Commission, NCQA also develops quality standards.[137] In order to receive NCQA accreditation, a health plan must undergo a rigorous onsite and offsite survey process that examines many factors, some of which include language access issues.[138] Factors include the availability of multilingual providers and the inclusion of policies and procedures concerning language services.[139] In addition, the NCQA publishes the Healthcare Effectiveness Data and Information Set (HEDIS), a per-

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[131] *Facts about the Joint Commission*, Joint Commission (Mar. 15, 2010), http://www.jointcommission.org/facts_about_the_joint_commission ("The Joint Commission evaluates and accredits more than 18,000 health care organizations and programs in the United States.").

[132] *See id.*

[133] Amy Wilson-Stronks & Erica Galvez, *Hospitals, Language, and Culture: A Snapshot of the Nation*, Joint Commission, 6 (2007), http://www.jointcommission.org/assets/1/6/hlc_paper.pdf.

[134] Elizabeth Eaken Zhani, *Joint Commission Publishes New Guide for Advancing Patient-Centered Care*, Joint Commission (Aug. 4, 2010), http://www.jointcommission.org/joint_commission_publishes_new_guide_for_advancing_patient-centered_care/.

[135] *See* Paras, *supra* note 72, at 50.

[136] *About NCQA*, *supra* note 129; Paras, *supra* note 72, at 49.

[137] *See About NCQA*, *supra* note 129.

[138] *See Health Plan Accreditation*, Nat'l Committee for Quality Assurance, http://www.ncqa.org/tabid/689/Default.aspx (last visited May 8, 2011); *2010 NCQA Health Plan Accreditation Requirements*, Nat'l Committee for Quality Assurance, at QI 4, RR 3, RR 4, http://www.ncqa.org/tabid/689/Default.aspx (follow "2010 NCQA Health Plan Accreditation Requirements" hyperlink) (last visited May 8, 2011).

[139] *2010 NCQA Health Plan Accreditation Requirements*, *supra* note 138, at QI 4, RR 3.

formance-measuring tool, which can be used by potential purchasers to assess a health plan.[140] Several HEDIS measures relate to the health plan's provision of language assistance services.[141] For example, health plans must report the number of multilingual clinicians and the number of multilingual member services staff and must also describe available interpreter services.[142] The NCQA has further encouraged the delivery of language access services through an award program that recognizes "health plans that have implemented initiatives to improve culturally and linguistically appropriate services and reduce health care disparities."[143]

C. *Common Law Tort Liability*

Because Title VI of the Civil Rights Act applies to federally funded programs and activities, much of the healthcare industry is subject to its reach.[144] Yet, one group, private physicians, is outside the reach of Title VI.[145] Nevertheless, several longstanding common law obligations could be used to require individual providers to offer language assistance services to facilitate communication.[146] A failure to provide adequate interpretation services could result in potential medical malpractice actions for inadequate medical care, breach of a patient's privacy rights, and lack of informed consent.[147]

An LEP patient could sue an individual physician for medical negligence on the basis of inadequate or inappropriate medical care.[148] Language barriers could furthermore lead to delayed or inaccurate treatment.[149] When a physician is unable to communicate with an LEP

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[140] *See HEDIS & Quality Management*, Nat'l Committee for Quality Assurance, http://www.ncqa.org/tabid/59/Default.aspx (last visited May 8, 2011); *What Is HEDIS?*, Nat'l Committee for Quality Assurance, http://www.ncqa.org/tabid/187/Default.aspx (last visited May 8, 2011).

[141] *See* Paras, *supra* note 72, at 53–54.

[142] *See id.* at 53.

[143] *See Recognizing Innovation in Multicultural Health Care*, Nat'l Committee for Quality Assurance, http://www.ncqa.org/tabid/453/Default.aspx (last visited May 8, 2011).

[144] *See* Title VI of the Civil Rights Act of 1964, Pub. L. No. 88-352, § 601, 78 Stat. 221, 252 (codified as amended at 42 U.S.C. § 2000d (2006)); Peterson, *supra* note 82, at 1442.

[145] *See* Bonnyman, *supra* note 82, at 69 (noting that private physicians are not subject to Title VI). Despite the fact that most private physicians receive Medicare payments, they are not considered recipients of federal funds and thus are not legally responsible under Title VI. *Id.* at 69–70; Khanijou, *supra* note 95, at 866.

[146] *See* Keers-Sanchez, *supra* note 40, at 558–59.

[147] *See id.*

[148] *See id.* at 559.

[149] *See* Khanijou, *supra* note 95, at 869; Chen, *supra* note 29. For example, an eighteen-year-old man's statement that he was "intoxicado," Spanish for nauseated, was treated for a

patient to obtain vital information, the risk of inadequate medical care and subsequent malpractice liability increases.[150]

Furthermore, physicians may also breach an LEP patient's common law right to privacy where an ad hoc interpreter is used in lieu of a professionally trained interpreter.[151] Ad hoc interpreters can be family members, friends, hospital support staff, or other patients who are spontaneously called on to facilitate the conversation between doctor and patient.[152] While ad hoc interpreters serve a useful immediate purpose, they almost always lack the requisite confidentiality training to deal with sensitive health issues.[153] Physicians can overcome this potential liability by ensuring that competent, professional interpreters are available to avoid the need to resort to a janitor or family member and risk violating an LEP patient's right to privacy.[154]

Informed consent is yet another area where physicians can be held legally responsible for a failure to provide language assistance to LEP patients.[155] The doctrine of informed consent is based on the theory of a patient's right to self-determination.[156] As such, a physician is required to disclose information regarding the benefits and risks of treatment alternatives in order to facilitate a patient's decision.[157] Thus, a patient must both know and understand the risks of the relevant treatment or care in order to consent, which can be difficult if language barriers obstruct effective communication.[158] Obtaining genuine informed consent can be a difficult task even with patients who do in fact speak English.[159] An LEP patient's inability to fully communicate with his or her physician can lead to misunderstandings, which can

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drug overdose for over thirty-six hours before doctors diagnosed a brain aneurysm. Flores, *supra* note 17, at 230. As a result of this miscommunication, the young man was rendered a quadriplegic. *Id.* A subsequent lawsuit resulted in a seventy-one million dollar malpractice settlement with the hospital. *Id.*

[150] *See* Flores, *supra* note 17, at 230.

[151] *See* Keers-Sanchez, *supra* note 40, at 562. Most states have recognized that disclosure of confidential medical information can constitute an invasion of an individual's right to privacy. *See, e.g.*, Commonwealth v. Brandwein, 760 N.E.2d 724, 729 (Mass. 2002).

[152] *See* Title VI of the Civil Rights Act of 1964; Policy Guidance on the Prohibition Against National Origin Discrimination As It Affects Persons with Limited English Proficiency, 65 Fed. Reg. 52,762, 52,769 (Aug. 30, 2000); Flores, *supra* note 17, at 231.

[153] Flores, *supra* note 17, at 231.

[154] *See id.*

[155] *See* Flinn, *supra* note 130, at 387, 394.

[156] *Id.* at 387.

[157] Khanijou, *supra* note 112, at 870.

[158] *See* Flinn, *supra* note 130, at 388–89.

[159] *See id.* at 386 (noting that informed consent can be difficult to obtain from those who are less educated, illiterate, or incarcerated).

then result in a lack of informed consent.[160] Moreover, the use of an ad hoc interpreter who cannot competently translate medical terminology can also result in a lack of informed consent.[161]

The aforementioned common law concepts constitute basic obligations any patient would expect from his or her physician, that is, an expectation of adequate medical care, respect for privacy, and the provision of enough information to make educated decisions.[162] Fortunately for private physicians, they can easily avoid tort liability with LEP patients by proactively providing translation and interpretation services.[163] The provision of language assistance services would seem a small price to pay to prevent any such liability.[164]

IV. A Possible Solution: The California Model

California, in particular, is known for the volume and strength of its laws and policies in ensuring language access in healthcare.[165] California has its own analog to the 1964 Civil Rights Act.[166] California Government Code section 11135(a) states in pertinent part:

> No person in the State of California shall, on the basis of race, national origin, ethnic group identification, religion, age, sex, sexual orientation, color, or disability, be unlawfully denied full and equal access to the benefits of, or be unlawfully subjected to discrimination under, any program or activity that is conducted, operated, or administered by the state or by any state agency, is funded directly by the state, or receives any financial assistance from the state.[167]

Indeed, California's Title VI analog is far broader than the federal law because it directly addresses language-based discrimination.[168] The

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[160] *See id.* at 394–95.

[161] *See* Flores, *supra* note 17, at 231.

[162] *See* Keers-Sanchez, *supra* note 41, at 558–59.

[163] *See id.*

[164] *See* Flores, *supra* note 17 at 230 (noting how misunderstanding one word cost a hospital seventy-one million dollars in a malpractice settlement).

[165] *See* Paras, *supra* note 72, at 43; Perkins & Youdelman, *supra* note 116, at 5. While California boasts over one hundred state laws addressing language access in various healthcare contexts, both broad and specific, I have limited my analysis to a select few that are particularly notable. *See infra* Part IV.

[166] Cal. Gov't Code § 11135 (West 2005 & Supp. 2011) (tracking the language of Title VI).

[167] *Id.* § 11135(a).

[168] *See* Cal. Code Regs. tit. 22, § 98210(b) (2010).

implementing regulations define "ethnic group identification" as "the possession of the racial, cultural or *linguistic* characteristics common to a racial, cultural or ethnic group."[169] Thus, California's specific reference to language makes it clear that LEP status is sufficiently equivalent to ethnic group identification to merit similar protections.[170]

In this way, California's language access legislation augments existing federal legislation by guaranteeing a right to language access.[171] Thus, while there is limited opportunity for an individual to bring a cause of action under Title VI, California's analog authorizes a private right of action where a covered entity fails to provide language access services.[172] Furthermore, actions with "the purpose or effect of subjecting a person to discrimination on the basis of ethnic group identification" violate California law.[173] As a result, the California law prohibits both intentional and disparate impact discrimination.[174] The issue in *Sandoval* is no longer relevant, therefore, because California's legislation expressly provides a cause of action for disparate impact discrimination.[175] The regulations, moreover, require recipients of state funding "to take appropriate steps to ensure that alternative communication services are available to ultimate beneficiaries."[176] Thus, by accepting state funding, recipients also assume an affirmative duty to provide interpretation and translation services to LEP individuals.[177]

California Government Code section 11135(a) applies to any entity that is operated or funded by the state, as well as to the state itself and its agencies.[178] The law also authorizes any state agency to create an administrative enforcement mechanism and procedure by which it can investigate any alleged violations and take disciplinary actions.[179]

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[169] *Id.* (emphasis added).

[170] *See id.*

[171] *See* Chen et al., *supra* note 1, at 363, 364.

[172] *See* Perkins & Youdelman, *supra* note 116, at 5. The statute was amended in 1999 to include a private right of action. CAL. GOV'T CODE § 11139 (West 2005). A covered entity includes any program run or financed by the state. *Id.* § 11135(a).

[173] CAL. CODE REGS. tit. 22, § 98101(i)(1).

[174] *See id.* § 98101(i), (j) (specifically noting that "the purpose or effect" of an action can give rise to a discrimination claim).

[175] *Compare* Alexander v. Sandoval, 532 U.S. 275, 293 (2001) ("Neither as originally enacted nor as later amended does Title VI display an intent to create a freestanding private right of action to enforce regulations . . . ."), *with* CAL. CODE REGS. tit. 22, § 98101(i), (j) (explicitly allowing a private right of action for disparate impact claims).

[176] CAL. CODE REGS. tit. 22, § 98211(c).

[177] *See id.*

[178] CAL. GOV'T CODE § 11135(a) (West 2005 & Supp. 2011).

[179] *Id.* §§ 11136–11138.

In addition, California has robust legislation that serves to improve language access for LEP patients.[180] For example, the Dymally-Alatorre Bilingual Services Act, enacted in 1973, ensures that Californians are able to make effective use of government services to which they are entitled.[181] This includes requiring state and local agencies to provide documents explaining their services translated into the languages of clients.[182] Additionally, when agencies serve a "substantial number of non-English speaking people," they are mandated to employ "a sufficient number of qualified bilingual persons in public contact positions" to service LEP persons.[183] For state agencies, a "substantial number" is defined as five percent or more of the population served by the state.[184] State agencies must conduct bi-yearly surveys to determine the number of bilingual staff and the number and percentage of LEP persons served.[185] Greater discretion is given to local agencies to determine what constitutes a "substantial number" of LEP persons.[186] The State Personnel Board ensures agency compliance with the Dymally-Alatorre Bilingual Services Act.[187] The State Personnel Board also provides guidance to agencies seeking to meet their legal obligations to serve LEP individuals.[188]

Furthermore, the Kopp Act specifically addresses services to LEP patients with respect to healthcare providers in the state.[189] Passed with an understanding that "access to basic health care services is the right of every resident of the state, and that access to information regarding

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[180] *See* Chen et al., *supra* note 1, at 363; Perkins & Youdelman, *supra* note 116, at 5.

[181] *See* Dymally-Alatorre Bilingual Services Act, CAL. GOV'T CODE § 7291 (West 2008) (providing "for effective communication between all levels of government in this state and the people of this state who are precluded from utilizing public services because of language barriers").

[182] *See id.* §§ 7295, 7295.2.

[183] *Id.* §§ 7292, 7293. What constitutes "a sufficient number of qualified bilingual [staff] persons" is noticeably undefined and at the agency's discretion. Plantiko, *supra* note 38, at 251 n.81.

[184] CAL. GOV'T CODE § 7296.2.

[185] *Id.* § 7299.4(b).

[186] *Id.* § 7296.2 (applying only to section 7292, which governs state agencies, but not to section 7293, which governs local agencies). In 2001, San Francisco passed an "Equal Access to Services" ordinance, which defines a substantial number of LEP persons as 10,000 city residents or five percent of those who use the department's services. S.F., CAL., ADMIN. CODE §§ 91.1, 91.2(j) (effective June 15, 2001), *available at* http://library.municode.com/HTML/14131/level1/CH91LAAC.html.

[187] CAL. GOV'T CODE §§ 7299.2–.6.

[188] *See Bilingual Services Program*, CAL. ST. PERSONNEL BOARD, http://spb.ca.gov/bilingual/index.htm (last visited May 8, 2011).

[189] CAL. HEALTH & SAFETY CODE § 1259 (West 2008); Paras, *supra* note 72, at 44.

basic health care services is an essential element of that right," the Kopp Act delineated seven discrete obligations for general acute care hospitals, along with two recommended steps.[190] The obligations include (1) adopting a language services policy; (2) ensuring the availability of interpreter services on site or by phone at all hours; (3) notifying LEP patients and families of the availability of interpreter services; (4) identifying a patient's primary language in hospital records; (5) preparing a list of qualified interpreters; (6) notifying staff to provide interpreters to all patients who request them; and (7) reviewing standardized forms to determine which should be translated.[191] The Kopp Act also urges hospitals to provide non-bilingual staff with picture and phrase sheets in order to communicate with LEP patients and to establish community relations with LEP communities.[192] The state licensing agency for hospitals is authorized to enforce compliance.[193]

To further its extensive efforts to promote language access services, California passed an unprecedented law in 2003.[194] California Senate Bill 853 requires all health and dental insurance plans to provide members with language assistance, in the form of oral interpretation and written translation, when seeking care.[195] Additionally, health insurance plans must provide language access services at all points of patient contact, including clinical encounters, free of charge.[196] This legislation is significant because it reaches beyond government agencies and aid recipients to govern the actions of private actors.[197] Indeed, California is alone in mandating that private insurers comply with its language access laws.[198] As a result, approximately one-third of the state's twenty-one million health plan members will potentially benefit from this law.[199] California's Department of Managed Health Care is

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[190] Cal. Health & Safety Code § 1259.

[191] *Id.* § 1259(c)(1)–(7).

[192] *Id.* § 1259(c)(8)–(9).

[193] *Id.* § 1259(e).

[194] Barclay, *supra* note 18.

[195] Cal. Health & Safety Code §§ 1367, 1367.04 (West 2008) (codifying Senate Bill 853); *see also* Cal. Ins. Code § 10133.8 (West 2005).

[196] *California Leads the Nation in Patient Health Rights*, Language Line Services (Apr. 2, 2009), http://www.languageline.com/page/news/140/.

[197] *See* Chen et al., *supra* note 1, at 364.

[198] Barclay, *supra* note 18. Although some states have considered similar legislation, Congress has yet to consider the issue seriously. *See id.*

[199] *See California Leads the Nation in Patient Health Rights*, *supra* note 196.

responsible for promulgating regulations to ensure compliance.[200] At the same time, health insurers must monitor their own language services programs to track compliance by plans and providers.[201]

V. Following California's Lead to Ensure a Legal Right to Language Access for LEP Patients

Given the limited federal protections of LEP patients' language access rights and California's progressive work in this area, it is clear that states can and should play an important part in ensuring an individual's right to language access in healthcare.[202] Already, much work has been done at the state level to dismantle language barriers that adversely affect the delivery of healthcare.[203] The movement at the state level reflects recognition of the primacy of language access services in healthcare.[204] States should adopt California's legislative model and furthermore ensure that adequate funding is provided to support the implementation and enforcement of language access legislation.[205]

Sandoval severely limited private enforcement of language access rights through the legal system.[206] California has successfully filled the gap left by *Sandoval* with legislation that prescribes a private cause of action to remedy disparate impact discrimination.[207] While California's

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[200] Melanie Au et al., *Improving Access to Language Services in Health Care: A Look at National and State Efforts*, Mathematica Pol'y Res., Inc., 3 (Apr. 2009), http://www.mathematica-mpr.com/publications/PDFs/Health/LanguageServicesbr.pdf.

[201] *Id.* Because full implementation of Senate Bill 853 was completed in 2009, data on the impact of the legislation is still forthcoming. *See id.* at 3–4.

[202] *See* Chen et al., *supra* note 1, at 363–64, 366.

[203] *See id.* at 363–64; *infra* Part III.A. Consistent with state efforts to ensure language access, Colorado, Massachusetts, and New Jersey have all passed legislation "link[ing] facility licensure to the provision of language services." Perkins & Youdelman, *supra* note 116, at 6; *see, e.g.*, Mass. Gen. Laws ch. 111, § 25J (2008) (requiring all emergency departments to provide access to trained interpreters for patients at all times and providing for a private right of action for denial of emergency care resulting from failure to provide interpreter assistance); Mass. Gen. Laws ch. 123, § 23A(b) (2008) (requiring acute psychiatric facilities to provide access to trained interpreters for patients at all times and providing for a private right of action).

[204] *See* Perkins & Youdelman, *supra* note 116, at 4.

[205] *See* Chen et al., *supra* note 1, at 365–66.

[206] *See* Alexander v. Sandoval, 532 U.S. 275, 285 (2001).

[207] *See* Perkins & Youdelman, *supra* note 116, at 5. There exists limited opportunity at the federal level to advance an individual's enforcement of language access rights in the healthcare context. *See* Plantiko, *supra* note 38, at 257. In 2004, Senator Edward Kennedy introduced a bill entitled "Fairness and Individual Rights Necessary to Ensure a Stronger Society: Civil Rights Act of 2004," which would have overturned *Sandoval* by expressly providing for a private right of action for disparate impact discrimination under Title VI. Daly, *supra* note 97, at 1044. It never became law. *Id.*

legislation undeniably helps to further language access rights, it is still insufficient in some respects.[208] For instance, Senate Bill 853 only reaches insured individuals, thus creating a gap in the guarantee of language access services for non-insured LEP individuals.[209] Recent federal healthcare reform legislation, however, will supposedly provide healthcare coverage to at least two-thirds of the uninsured population in California, thus helping to further close the gap left by Senate Bill 853.[210]

Other states should follow California's example in creating a legal right of language access for LEP patients.[211] Although California's model is admittedly non-exhaustive, it is the nation's policy leader nonetheless, with the most comprehensive laws on language access.[212] Extending the obligation to provide language access services to private actors, such as health plans, in the healthcare industry is a necessary and substantial step towards improving access for LEP patients.[213] Additionally, the recognition of a private right of action could bring much-desired relief to individual LEP patients who have been wronged.[214] In following California's lead to ensure a legal right to language access, other states should make sure to replicate the hallmark of California's far-reaching legislation, that is, its emphasis on the proactive provision of language access services in healthcare settings.[215]

Conclusion

Language barriers deprive LEP individuals of access to quality healthcare, often at a time when it is most urgently needed. The fact

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[208] *See* Plantiko, *supra* note 38, at 256 (calling the Dymally-Alatorre Bilingual Services Act insufficient); *California Leads the Nation in Patient Health Rights*, *supra* note 196. One scholar notes that California's Dymally-Alatorre Bilingual Services Act "contains no monitoring provisions for compliance and no enforcement mechanisms." *Id.* at 256. However, the State Personnel Board is in fact tasked with keeping agencies accountable for their Dymally-Alatorre obligations. Cal. Govt. Code §§ 7299.2–.6 (West 2008).

[209] *See* Cal. Health & Safety Code § 1367.04 (West 2008).

[210] *See* Victoria Colliver, *California Impact: State Stands to Gain the Most from Reform*, S.F. Chron., Mar. 22, 2010, at A1. A significant group of people will remain uninsured because, despite the broad reach of PPACA, the law expressly excludes illegal immigrants. *See* Devon Herrick, *Crisis of the Uninsured: 2010 and Beyond*, Nat'l Center for Pol'y Analysis, 2 (Sept. 17, 2010), http://www.policyarchive.org/handle/10207/bitstreams/95823.pdf.

[211] *See* Chen et al., *supra* note 1, at 365–66.

[212] *See* Au et al., *supra* note 200, at 3.

[213] *See id.*

[214] *See* Cal. Gov't Code § 11139 (West 2005); Daly, *supra* note 97, at 1024.

[215] *See* Chen et al., *supra* note 1, at 366; Au et al., *supra* note 200, at 3; Perkins & Youdelman, *supra* note 116, at 5.

that the American health system denies access to millions of people is a serious problem that must be remedied. Increased language services can provide access to critical healthcare services. Furthermore, language services can ensure effective physician-patient communication and lead to improvements in healthcare quality, patient experience, and resource utilization. Thus, more can and must be done to reduce miscommunication due to language differences in healthcare delivery.

Although a federal mandate to provide language access services to LEP patients can be found in Title VI of the Civil Rights Act of 1964, the law has been poorly enforced. California has emerged as a leader in state efforts to improve language access in healthcare by supplementing the legal and enforcement gaps in the federal framework with extensive legislation to further strengthen the legal right to language access. Thus, California should serve as a model for other states in guaranteeing LEP individuals the right to language access in healthcare.